STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745051	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents hazards and supervision. The facility failed to ensure Resident #1's fall mat was in place, and the bed was in low position on 02/12/2026 at approximately 7:00 a.m., when he was found lying on the floor. The noncompliance was identified as PNC. The noncompliance began on 02/12/2026 and ended on 02/12/2026. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for falls with the possibility of injury, including fractures.Findings included: Record review of Resident #1's face sheet, dated 03/02/2026, reflected a [AGE] year-old male admitted to the facility on [DATE], diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive - decline where the specific cause has not been determined, and the person shows no significant behavioral or mood disturbances), reduced mobility (having a significantly limited ability to move around , walk safely and without pain), repeated falls (experiencing two or more falls within a 12-month period), abnormalities of gait and mobility (irregularities in walking, running, or movement patterns), history of transient ischemic attack, and cerebral infarction without residual deficits (a temporary blockage of blood flow to the brain, causing stroke- like symptoms (e.g. , weakness, numbness, and/or speech issues) the lack of blood flow was brief enough that no permanent brain tissue damage or lasting), and lack of coordination (a condition causing shaking, unsteady, or clumsy movements due to impaired muscle control). Record review of Resident #1's Quarterly MDS Assessment, dated 01/13/2026, reflected Resident #1 had a BIMS score of 3 which indicated his cognition was severely impaired. Resident #1 had limited range of motion (the specific, often limited range of joint movement necessary to independently perform daily activities, such as reaching overhead, walking, or sitting) on one side of upper extremity and both sides of lower extremity. Resident #1 was dependent on staff for the following: personal hygiene, putting on/taking off footwear, upper and lower dressing, and toileting hygiene. He required substantial/ maximal assistance (helper does more than half the effort) for the following: oral hygiene and showers. Resident #1 required partial/moderate assistance (helper does less than half the effort) with all transfers. Review of Resident #1's Comprehensive Care plan was revised on 1/22/2026, indicated Resident #1 was at risk for injury for falls. Interventions included (initiated on 06/29/2025) Resident #1 required fall mat beside bed when lying in bed. Resident #1 needed a safe environment with a working and reachable call light, the bed in low position at night. The care plan indicated Resident #1 had an ADL self-care performance deficit such as: Interventions included: Required assistance with two staff for transfers, bed mobility, and bathing. Required one staff assistance with bed mobility. Required a mechanical lift (Hoyer) for all transfers.Used a wheelchair. The care plan indicated Resident # 1 had limited physical mobility related to weakness (a reduction in muscle strength, where you feel as though you need to exert extra effort to move your arms, legs, or other muscles). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Intervention: Resident #1 is totally dependent on staff for locomotion. Record review of Resident #1's Activity Note, dated 02/12/2026 at 8:45 AM, reflected Called to resident's (Resident #1) room, resident (Resident #1) had fallen from bed onto the floor. Resident (Resident #1) had hit his head and mouth. Resident (Resident #1) stated he was trying to get up. Performed initial assessment, received from LVN A. LVN A stayed with resident (Resident #1) while RN B contacted 911 with report and request for transport. LVN A called Resident #1's daughter and reported the incident with her father (Resident #1) and transport him to hospital. RN B called the Administrator, attempted to call director of nurses, Nurse Practitioner and left message. Record review of Resident #1's Transfer Form to hospital, dated 02/1/2026 at 8:45 a.m. reflected Resident #1 was transferred to hospital related to a fall with a possible head injury. Record Review of Resident #1's Nursing notes dated 02/12/2026 at 12:37 p.m., reflected Resident (Resident #1) returned from hospital ER status post fall from bed this morning (02/12/2026). Residents (Resident #1) treatment included laceration wound care, naproxen 250 mg and amoxicillin-clavulanate 875-125 mg tablet for 14 days. Residents (Resident #1) TDAP () was updated. Record Review of Resident #1's Weekly Skin Assessment notes, dated 02/12/206 at 1:15 pm, reflected Resident #1 had an abrasion to right side of lip and inside of mouth no measurements were documented. The assessment indicated Resident #1 had laceration on top of right side of head, 3 staples there were no measurements documented. Record Review of Resident #1's Neuro Assessment, dated 02/12/2026 at 2:20 p.m. reflected the following;Blood Pressure-126/78Pulse 81Respirations 17Eyes opening- spontaneouslyVerbal Response - Confused- not oriented, but communication is coherent (this is his baseline)Obey commands; example stick out your tongue, squeeze my handPupils equal and reactive to lightHand grips equal- No (this is his baseline)The physician or Nurse Practitioner should not be notified regarding a sign of neurological change. Record review of Resident #1's hospital records dated 02/12/2026 reflected Resident #1 had the following: 1. Procedure of Lower lip Laceration on lower lip - 1 cm No full thickness lip lacerationNo Foreign bodiesNo tendon involvementNo nerve involvementNo vascular damageSkin closure with glueRepair type was simple 2. Procedure of Laceration Repair Local AnesthesiaBody area was the head/neckLocation details was the scalpLaceration length: 2 cmNo foreign bodiesNo tendons involved No vascular damageUsed syringe to irrigateIrrigation solution was salineAmount of cleaning: extensiveNo debridementNo degree of underminingSkin closer- staplesNumber of sutures-3Repair type was simple 3. Fractures - no acute fractures (Spine, Neck, head)Brain Parenchyma; No acute hemorrhage. No mass effect or herniation(protrusion of an anatomic structure from its normal anatomic psotion). Record review of (Resident #1, Resident #2,Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9) care plans interventions reflected:fall mats beside the bed when resident was lying in bed was on each of these residents care plan. Record review on 03/02/2026 of CNAs C personnel record reflected CNA C was suspended on 02/12/2026 until the facility investigation was completed. Record review on 03/02/2026 of the facility investigation report dated 02/19/2026 reflected the following:CNA C was suspended pending investigationAssessed Resident #1Revised Resident #1 care plan.Re-in serviced all staff on how to use Kardex, abuse/ neglect, pain management, trauma informed care, fall prevention, fall risk, and shift change rounding.Interviewed 10 staff members per week to ensure they have the knowledge to locate information in Kardex related to fall intervention. This will be ongoing for the next 3 months.During stand-up morning meetings ADON, DON, Administrator, Activity Director, Dietary Manager, MDS Coordinator, Social Worker, - all department heads and Nurse supervisor) in am reviewed residents at risk for falls and residents had a recent fall to ensure all interventions are in place. This is ongoing for next 3 months.AD Hoc QAPI meeting was held with the medical director, Administrator, Social Worker, and Director of Nurses about the plan the facility has in place after Resident #1's fall incident on 02/12/2026.Director of Nurses and ADON will meet 3 times per week and follow up with fall interventions. The Director of Nurses and ADON will enter each residents rooms (fall risk residents) and ensure fall interventions are in place. This will be ongoing for next (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	three months.Director of Nurses will at least five times per week monitor residents with unwitness falls or resident hit their head during a fall to ensure neuro checks and assessments are completed and physician was notified.This will be ongoing for the next three months.Director of Nurses or Designee will interview residents with a fall to determine if the resident had pain and what level was the pain. Interview on 03/02/2026 at 12:00 p.m., CNA C stated she worked from 6:00 p.m. to 6:00 a.m. on 02/11/2026 to 02/12/2026. She stated she assisted Resident #1 to bed approximately 6:00 p.m. on 02/11/026. She stated he was asleep her entire shift. CNA C stated she did not see any fall mats in Resident #1's room. She stated he was lying on his back in middle of the bed whenever she entered Resident #1's room. CNA C stated she had been a CNA approximately 20 years. She stated she knew her residents and the care the residents required from nursing. CNA C stated it was nurses responsibility to inform CNAs when there were any changes with the residents. She stated she was aware of the Kardex for CNAs to review for the care of each resident. CNA C stated Resident #1 did not have fall mats beside his bed and she was not aware he required fall mats. CNA C stated the last time she saw Resident #1 he was in bed asleep, and his bed was in low position. CNA C did not respond to any other questions about fall mats with Resident #1, his condition. She became agitated when questions was asked about Kardex, Resident #1's bed/fall mats, if he should have had fall mats, etc. The interview was stopped due to her agitation and refusing to answer questions. Interview on 03/02/2026 at 1:13 p.m., via phone call CNA D stated she was working on 02/12/2026 from 6 a.m. to 6 p.m. She stated she was making her morning rounds and when she entered Resident #1 room approximately 6:50 a.m., she observed Resident #1 on the floor beside his bed with blood coming from his head. She stated she asked CNA E to come to Resident #1's room and help her. She stated she requested CNA E to stay with Resident #1 while she found the nurse. She stated she saw RN B and explained she was needed immediately in Resident #1 room he had fallen and was bleeding. She stated RN B immediately went to Resident #1's room and RN B asked her and CNA E to find LVN A. LVN A entered Resident #1's room and RN B and CNA E was talking. She stated RN B exited the room and called 911. CNA D stated when she entered the room Resident #1was on the floor next to the bed. She stated his head was toward the top of the bed and his legs was toward the end of the bed. CNA D stated he was not lying on the floor mats and the bed was in high position. She stated the floor mats was rolled up and leaning against the wall near the window. CNA D stated he was required to have his bed in low position and fall mats were always required to be beside his bed whenever he was lying in bed. She stated Resident #1 was a fall risk. CNA D stated when she asked Resident #1 what happened, he stated he rolled out of bed. She stated if the fall mats had been on the floor beside the bed and the bed was in low position she did not believe he would have had an injury or a head injury. CNA D stated she had been in-serviced on fall protocol and abuse/neglect. She stated if you found a resident on the floor the CNAs were not to touch the resident and immediately call for a nurse. She stated the CNA was to follow the nurse guidance. CNA D stated examples of abuse was the following: physical such as hitting, yelling at a resident, and can be sexual. She stated examples of neglect was not assisting a resident to the bathroom, not giving resident their meals, and/ or not giving resident their medications. In an interview on 03/02/2026 at 1:27 p.m., RN B stated she was on 200 hall and CNA D explained to her she was needed in Resident #1's room immediately he had fallen and there was blood coming from his head. She stated she entered Resident #1 room and he was lying on the floor. She stated his head was facing the head of the bed and feet was toward end of the bed. She stated there was blood on the floor and appeared to be coming from his head. RN B stated resident was approximately 2 or 3 feet from the side of his bed. She stated she asked CNA D and CNA E to find LVN A while she stayed with Resident #1. She stated LVN A entered the room within 5 minutes. RN B stated LVN A asked her to immediately go to the nurses station and call 911. She stated she called 911 and EMS arrived at the facility and transported Resident #1 to the hospital. RN B stated Resident #1 was not lying on fall mats and she did not see any fall mats under him or by the bed. She said she did not notice if there were any fall mats in the room or if the bed was in low position. RN B stated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	she called the physician on call and left a message, she notified the responsible party, DON, and the Administrator. She stated Resident #1 was a fall risk prior to his fall on 02/12/2026. RN B stated she did not recall if Resident #1 required fall mats or needed his bed in low position prior to his fall on 02/12/2026 and would need to review his chart to find the information. In an interview on 03/02/2026 at 2:41 p.m., LVN A stated CNA D and CNA E came and got her and said she was needed immediately in Resident #1's room that he fell and blood was on the floor. She stated she immediately went to Resident #1's room and Resident #1 was lying on the floor and there was blood on the floor. LVN A stated Resident #1's head was toward the front of the bed and legs were toward the end of the bed. She stated he was lying on the floor and was not lying on any fall mats. LVN A stated she instructed RN B to call 911 immediately and she would stay with Resident #1. She stated RN B called 911. LVN A stated she did not see any floor mats beside Resident #1's bed and did not look in the room to notice if there were fall mats in the room. LVN A stated the bed was not in the lowest position. She stated she thought the bed was mid-position not high and not low. She stated she had been in-serviced on fall protocol, neglect and abuse. She stated if a CNA or any staff except for a nurse found a resident on the floor the staff was not to touch the resident until the nurse observed the resident and did an assessment. She stated she did not have time to do an assessment on Resident #1 he needed to immediately be transferred to the hospital. LVN A stated the nurse was expected to complete head to toe assessment, pain assessment, and obtain vital signs. She stated the physician, Responsible Party, DON, and Administrator were to be contacted. LVN A stated nurses were to follow the guidance of the physician. She stated abuse was when a resident was cussed, hit, or stole money from a resident. She stated neglect was not giving resident their medications, not changing the resident if they were soiled, refusing to assist resident to the bathroom. In an interview on 03/02/26 at 2:46 p.m., CNA E stated CNA D yelled for him to come to Resident #1's room. He stated when he entered Resident #1's room he saw Resident #1 lying on the floor and blood coming from his head. CNA E stated Resident #1 was lying on the floor and there was no floor mats beside his bed. CNA E stated he saw floor mats rolled up against the wall. He stated Resident #1's bed was in high position. CNA E stated he stayed with Resident #1 when CNA D exited the room immediately when he entered to find a nurse. He stated RN B entered the room within less than 5 minutes but did not recall the exact time she entered the room. He stated it was beginning of the shift and he worked 6 a.m. to 6 p.m. on 02/12/2026. CNA E stated when RN B entered the room, she requested for him and CNA D to find LVN A and ask her to come and assist with Resident #1. CNA E stated within 5 minutes or less they (CNA E and CNA D) found LVN A and CNA D told LVN A she was immediately needed in Resident #1's room he had fallen and was bleeding. He stated LVN A immediately walked to Resident #1's room and instructed RN B to go and call 911. CNA E stated RN B called 911 immediately. He stated he exited Resident #1's room CNA D and LVN A was in the room. He stated he had been in-service on fall protocol, abuse, and neglect. He stated if he found a resident on the floor, he would not touch the resident, he would call for help and wait for the nurse and follow the nurses orders. CNA E stated neglect was when staff would not give resident some water, refused to feed a resident or take a resident to the bathroom. He stated abuse could be cussing a resident, hitting a resident, or stealing money or anything from a resident. He stated he had been in-service on falls, abuse and neglect many times and the last time was in February 2026. He stated he did not recall the exact date. Observation on 03/02/2026 at 3:10 p.m. of residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9) rooms revealed all residents had fall mats beside their beds. Residents were lying in their beds. There were no concerns noted. In an interview on 03/02/2026 at 4:15 p.m., LVN A stated if fall mats had been beside Resident #1's bed and he had fallen on the fall mats there was a possibility he may not have been injured, or his injury may not have been where he acquired a laceration to his head. In an interview on 03/02/2026 at 4:25 p.m., RN B stated there was a possibility if Resident #1's bed had been in low position and he had fall mats beside his bed he would not have sustained an injury and the laceration to his head might have been (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	prevented. In an interview on 03/02/2026 at 5:11 p.m. CNA F stated she had given Resident #1 care numerous times (she did not recall how many times per week or month). She stated she had given care to Resident #1 on the day shift (6 a.m. to 6 p.m.) and on night shift (6 p.m. to 6 a.m.). CNA F stated Resident #1 was a fall risk prior to his recent fall in February 2026. She stated he required fall mats beside his bed whenever he was in bed. She stated his bed was to be in low position. CNA F stated she worked the night shift and she did not see any fall mats in room she would not assist Resident #1 to be until she found fall mats and placed them beside his bed after she assisted him to bed. CNA F stated she would ensure his bed was in low position. She stated it was on the Kardex prior to his fall in February 2026 (when he had cut on his head) stating Resident #1 was a fall risk, he was to have fall mats and bed in low position. She stated she had been in-service on fall protocol, abuse and neglect. She stated if witnessed a fall or saw a resident on the floor she was not to touch the resident until the nurse entered the room and assessed the resident. She stated she was to follow the nurses advice. CNA F stated abuse was when someone slapped a resident, yelled at a resident or could be sexual abuse. She stated neglect was refusing to give resident their meals, refusing to change their briefs, and refusing to give them water during the day. She stated she had been in-service on fall protocol, abuse and neglect many times and most recently was few weeks ago in February 2026. She stated she did not recall the date. In an interview on 03/02/2026 at 5:30 pm, The Administrator stated all staff was expected to follow care plan interventions. She stated the care plan was in place for the staff to know each resident's physical and emotional needs to prevent falls, injuries, becoming more depressed or have emotional needs. She stated if a staff did not understand the care plan or Kardex the staff was to ask Director of Nurses, Nurse Supervisor or Administrator. She stated if the fall mats were beside Resident #1's bed there was a possibility Resident #1 might not have sustained a laceration. She stated nurses were responsible to ensure CNAs followed the care plan of the Residents. Record review of the facility's Fall Policy, not dated, reflected Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Environmental: utilize low bed if indicated.